AN ANALYSIS
OF CASES OF ORGANIC URETHRAL STRICTURE

JOHN D. HILL

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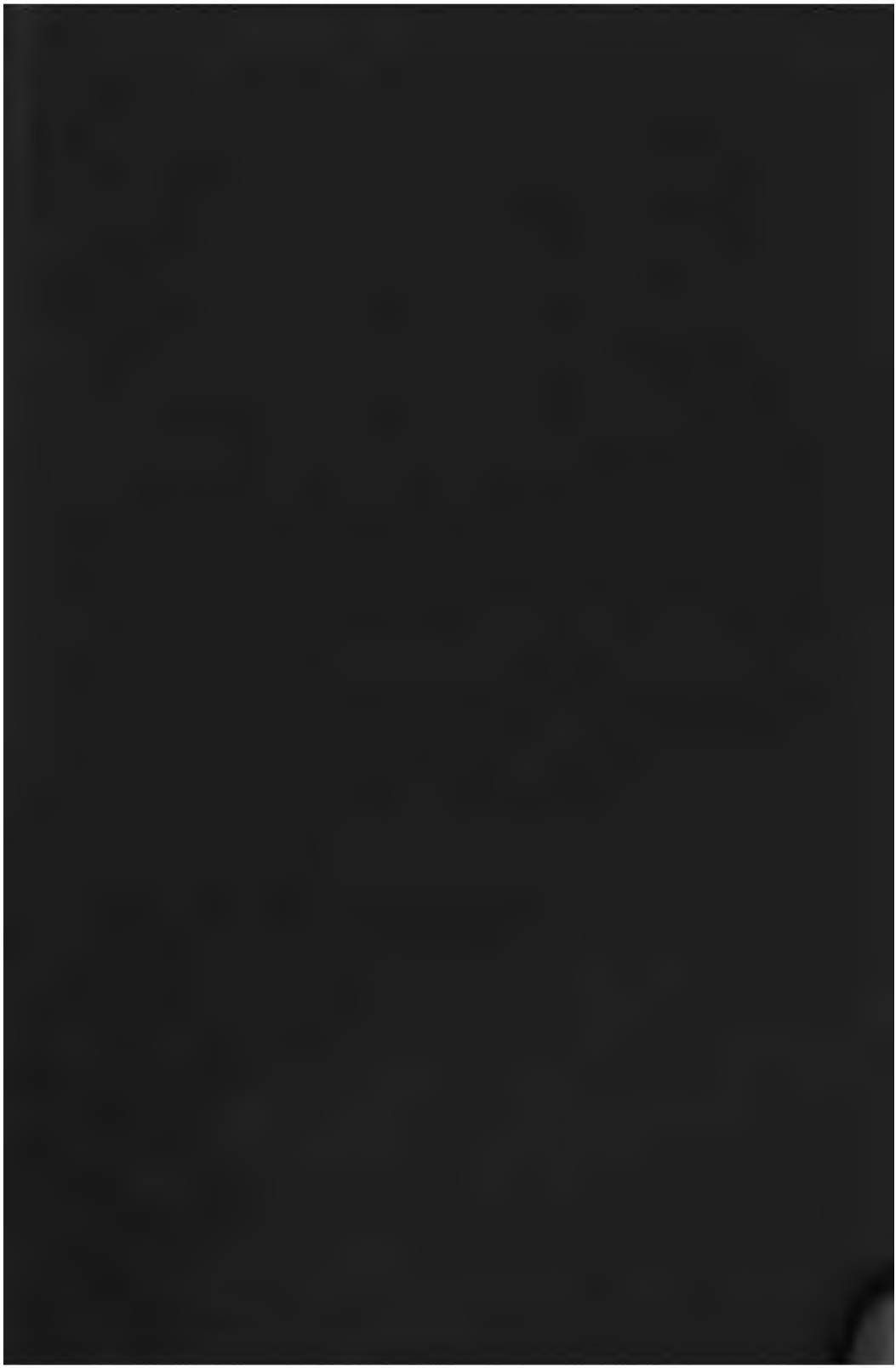

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OF WHICH ONE HUNDRED AND TWENTY CASES WERE SUBMITTED TO HOLT'S OPERATION, AND TWENTY TO PERINÆAL SECTION.

BY

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MDCCCLXXI.

PREFACE.

THIS monograph was, in substance, read before the Medical Society of London, on November 14, 1870; and, as its title expresses, consists of an analysis of one hundred and forty cases of organic urethral stricture, which have been submitted to surgical treatment.

It aims at *firstly*, a safe and ready method of treating the disease; *secondly*, a classification of cases in which a splitting operation is to be preferred to a cutting one, and *vice versâ*; thirdly, a brief consideration of the local, constitutional, and concomitant conditions affecting treatment. And in the hope that the facts here collected, and the inferences derived therefrom, may prove not without interest to practical surgeons, I venture, in deference to a wish expressed by many of my professional brethren, to publish the monograph in its entirety.

J. D. H.

17, GUILFORD STREET, RUSSELL SQUARE,
March, 1871.

AN ANALYSIS,

ETC.

Mr. President and Fellows,

The surgical treatment of organic urethral stricture has been a subject of special interest to me for some years past, the practice of the Royal Free Hospital having afforded me facilities for testing the relative advantages of the several measures which have been from time to time advocated by surgical authorities; and from the tedious process ordinarily pursued in gradually dilating a stricture, together with the difficulty which is often experienced in persuading patients to spare sufficient time for the satisfactory completion of that process before the disease becomes far advanced, or serious complications ensue, I have been led to consider what is a simple, safe, and rapid mode of treatment in the great majority of cases, and what conditions should guide the surgeon in his selection of the most appropriate time for operating; and in the smaller number of cases which are not amenable to such treatment, what proceeding will attain the end with the least amount of danger to the patient's life.

In order to justify the conclusions at which, after mature reflection, I have arrived upon these points, I have the honour to place before you an analysis of one hundred and forty cases of organic urethral stricture, which I have treated at the Royal Free Hospital. Of that number one hundred and twenty cases have been submitted to Holt's operation, and twenty to perinæal section, sometimes called Syme's operation.

Now surgeons have entertained different opinions respecting the safety of the sudden forcible dilatation or splitting of a stricture, both in regard to its immediate and remote local effects, and its indirect consequences to the nervous system; and seeing that gradual dilatation, even under the most favourable circumstances is a tedious process, and not always exempt from serious results, I resolved to inquire into the conditions favourable to stricture splitting, and the circumstances under which a cutting operation is to be preferred—a proceeding manifestly necessary when dilatation fails. With much gratification I therefore now venture to lay before you my experience on the several advantages of these operations respectively.

Surrounded by so many distinguished Fellows of this Society, it is perhaps unnecessary for me to do more than hint at the circumstances which guide us in deciding the question of any surgical opera-

tion, whatever be its character or extent. I refer to the local and constitutional conditions of the patient. And yet, sir, I would respectfully submit that the importance of interpreting this question aright can hardly be over-estimated, since the issue of many operations, whether great or small (*cæteris paribus*) rests to a certain extent with the individual judgment of the surgeon, and upon his prudent selection of the exact period when nature will best complete the work of repair; and perhaps in no class of cases is this more necessary than that which we are about to consider. But with all our discrimination, care, and foresight, we must also admit that fatal consequences do sometimes follow even the most trivial operations. Some error in the vital economy at first unsuspected may develop at any period after operation, elude our grasp, and lead to a fatal issue.

Who amongst us is unfamiliar with the formidable diffuse cellular inflammation which damages or destroys a whole limb, and sometimes the life of a patient, after some trifling puncture or abrasion of an extremity? What experienced surgeon has not witnessed fatal pyæmia, phlebitis, or tetanus from an apparently trivial wound—ay, even from a contusion? Why, therefore, should urethral operations be exempt?

Too much stress cannot be laid upon this point, in order fully to comprehend why successful results have attended operations in the hands of some

surgeons, whilst with others, equally skilful and distinguished, fatal consequences have ensued; and from my own personal experience much also seems to depend upon attention to details both in operations and in the treatment before and after them—points in themselves apparently insignificant, but in the aggregate sufficient to turn the balance in favour of or against success.

With these observations, I will proceed to analyse my cases, which, for the sake of convenience, may be arranged under four heads, viz. :—

1. Single Stricture.
2. Multiple Stricture.
3. Stricture with Complications.
4. Cartilaginous Undilatable Stricture.

I. Single Stricture.

Definition.—By single stricture I mean a limited contraction of any part of the urethra from the triangular ligament to the meatus urinarius, whether from disease or injury. This may be of any kind, but is commonly met with as a membranous band stretching across the canal at its superior or inferior part, and more seldom laterally. Sometimes we find a ring of membrane, at other times a spheroidal nodule of fibrous tissue, a fusiform callous mass, or a cartilaginous irregular substance.

The situation and extent of a stricture may sometimes be determined by external manipulation of the urethra, particularly in the nodular, fusiform, and cartilaginous varieties; and corroborative evidence is obtained by repeating this method of examination after the passage of a silver catheter or sound.

The membranous varieties are diagnosed pretty accurately by passing a sound as far as the obstruction, when the instrument should be marked at the meatus; and the penis, scrotum, or perinæum, as the case may be, at the point of the instrument. Now the sound will indicate the degree of resistance, the sensation communicated to the hand on yielding, the position of the opening, and the amount of grasping of the stricture; and these local signs combined yield the surgeon sufficient information of the character of the stricture for all practical purposes. Sometimes, however, I have ascertained its shape more accurately from the impress on a soft bougie.

With regard to symptoms generally, they appear to be much influenced by the temperament and habits of patients. Occasionally a simple form of membranous stricture will be followed by severe local and constitutional disturbance; and perhaps I cannot do better than give a typical case in illustration thereof.

A gentleman from Scotland, not more than twenty-eight years of age, of very nervous temperament, who had resided in India about eight years, and lived

rather indiscreetly, called upon me a month ago with retention of urine.

A year previously symptoms of stricture set in, and latterly he had suffered from dyspepsia, a capricious appetite, and habitually confined bowels. Micturition, which was accompanied with rigors, was very frequent and painful, and during the preceding few weeks had amounted to ardor urinæ. Lumbar pains had also much troubled him, his appetite had left him, and he was losing flesh. He stated that the stream was hardly larger than a hair-pin, and sometimes was expelled only in drops.

On examination of the urethra I found the stricture situated at the bulbo-membranous part, which was excessively tender both to external pressure and to a catheter (No. 3), but the resistance was not great. As the instrument slipped through, by slightly withdrawing and depressing its point a semilunar band was detected at the upper part and the aperture at the lower part of the stricture. I withdrew three pints of alkaline ammoniacal urine, which was subsequently examined and found to contain phosphates, mucus, and albumen, but its specific gravity measured 1018. Four days afterwards I split the stricture and introduced a No. 10 catheter. Eleven days later he returned to Scotland with instructions to have a No. 11 instrument passed once a fortnight. His health at that time was greatly improved, the urine having

become normal and the lumbar pain having subsided. Nearly one-half the total number of my cases consists of single stricture, and these—sixty-nine in number—have been submitted to Holt's operation.

Situation.—The disease was situated in the membranous portion of the urethra in five cases; at the bulbo-membranous part or thereabouts in forty cases; in the spongy part one inch from the bulb in ten cases; two inches from the meatus in five cases; about three-quarters of an inch from the meatus in three cases, and at the meatus itself in six cases.

Description.—Of the *forty cases* in which the *bulbo-membranous* portion was affected, we find twenty-eight apparently of a bridle character, with the opening along the superior or inferior wall of the urethra; five of an annular description, with the aperture at or near the centre; six apparently semilunar, with the opening on the right or left wall respectively (two right, four left); and one of a fusiform character, with the orifice in the centre.

Of the *five cases* where the *membranous portion* was implicated, two were of a bridle character, with the orifice at the inferior part of the stricture, and three of a tough cartilaginous nature, with the opening at or near the centre. These ranged from one-sixth to one quarter of an inch in extent, as shown by the impress on a soft bougie.

Of the *ten cases* occupying a situation *one inch in*

the front of the bulb, six were of a nodular or fusiform shape, to be felt encircling the instrument (about the size of a pea); and four were of a bridle nature, with the aperture at the superior part of the stricture.

Of the *five cases two inches from the meatus*, four were of a bridle nature with a lateral aperture, and the fifth was fusiform.

Of the *three cases about three-fourths of an inch from the meatus*, two were fusiform with the opening by the right, and *one* nodular with the aperture along the left wall of the urethra.

Of the *six cases at the meatus*, in four the orifice was contracted to the size of a No. $\frac{1}{2}$ catheter drawn by cicatrix tissue to one side or the other, and overlapped by a portion of the glans penis, which chancres had more or less excavated; in one case the lips of the meatus were adherent to a great extent, and in another the greater part of them was absent—the aperture being at the inferior part.

Probable Cause.—In twenty cases the patients had suffered from protracted gonorrhœa; in twenty-four it had been contracted twice, in nine thrice, and in five four times; and not unfrequently before recovery from a previous attack. One case of stricture in the membranous portion was attributed to a calculus which had been discharged through the perinæum by ulceration and abscess, and another of the cartilaginous variety to injury (a blow to the perinæum).

In the three cases about three-quarters of an inch from the meatus we had a history of urethral chancre; of the six at the meatus four were due to phagedænic ulceration extending into the urethra, one to orificial chancre, and in another sloughing phagedæna had destroyed the upper part of the glans penis, with the greater portion of the meatus urinarius.

Period between Cause and First Symptoms of Stricture.

After gonorrhœa the shortest period was	2 years.
After gonorrhœa the longest period was	13 years.
After chancre the shortest period was	10 months.
After chancre the longest period was	3 years.
After injury the shortest period was	4 months,
the longest period	18 months.

Condition of Stricture on Admission, and Interval before Operation.—Symptoms chiefly of *congestion* were present in twenty-four cases; and dilatation was employed on the second, third, or fourth day after admission.

Symptoms of inflammation were shown in five cases, of which three were associated with albuminous urine, and two with serous infiltration in

and around the stricture. Here dilatation was practised at a range of from ten to fifteen days.

Spasm was the chief symptom in forty cases, of which one was dilated on the 3rd day, twenty-six on the 4th, three on the 5th, two on the 6th, five from the 7th to the 10th inclusive, and three associated with perinæal, scrotal, or recto-vesical fistulæ from the 11th to 12th days after admission.

Limit of Age.—The youngest patient operated upon was 22, and the oldest 77 years of age.

II. Multiple Stricture.

Definition.—By multiple structure I mean a contraction of the urethra at intervals—viz., at two, three, or more points in its course from the meatus to the triangular ligament; and so far as my experience goes, this affection is not primarily the result of external violence.

The character of the deposit is sometimes nodular or bead-like, at other times fusiform, and not unfrequently we have a combination of these conditions—that is to say, an upper stricture nodular, a lower fusiform. On the introduction of a catheter its size, situation, and degree of resistance may be definitely ascertained. There is, however, one point worthy of notice—namely, the difficulty which is sometimes experienced in liberating the catheter from the grasp of the first stricture. This I have generally accom-

plished by partially withdrawing the instrument two or three times, and then carefully stretching the penis upon it.

The lowermost stricture, usually of a fusiform nature, gives more trouble than the others, sometimes from its dense character, at other times from intensity of spasm in the upper or middle strictures, or in itself. With regard to symptoms generally, they seem to be chiefly aggravated by sudden reductions of temperature, especially when associated with cold east winds, and not uncommonly the gradually increasing difficulty in micturition with all its attendant evils to the urinary organs, is suddenly brought to a crisis by habits of intemperance. For instance (Case IV.), a patient aged 60, who had suffered 40 years from more or less difficulty in urination, had always dribbling upon any sudden diminution of the atmospheric temperature, particularly with east winds, but on no occasion had he incurred actual retention until a fortnight before admission, when he imbibed rather freely of Scotch whisky at the death of a relative; then his troubles began with, first, retention, next irritability of the bladder, and finally incontinence and dribbling. The urine was albuminous, phosphatic, containing mucus, and of lower specific gravity than normal (1015), and he had much lumbar pain, repeated rigors, and loss of appetite. His pulse was quick (118) and

thready, his countenance anxious, and he was quite prostrate. The strictures, three in number, were situated in the spongy and membranous portions of the urethra respectively, and were very spasmodic in character; the upper two in the spongy part were nodular and about the size of a large pea, the lower, although differing in shape (fusiform), was not much larger.

After six days' treatment all the more severe symptoms had subsided, and Holt's operation was performed. Five days subsequently he was well enough to leave the hospital with instructions as to future catheterism.

Of *multiple stricture* there are thirty-one cases on my list, in twelve we had triple, and in nineteen bifold stricture.

Situation.—Of the triple variety the first stricture was usually situated in the spongy part of the urethra, about two inches from the meatus; the second midway between this and the bulb; and the third about the bulbo-membranous junction, extending more or less into the bulbous or membranous portions respectively.

Of the bifold class the first stricture was generally placed about halfway between the meatus and the bulb; the second at the bulbo-membranous junction, or in the membranous portion itself.

Description.—In the triple stricture the character of the first and second was, as a rule, nodular, and the third fusiform, or nodular. When fusiform, more or

less extensive, varying from one-third to three-fourths of an inch in length. In all these cases the aperture seemed about the centre of the deposit.

In the bifold variety the strictures were either both nodular, or the upper was nodular and the lower fusiform.

The nodules varied in size from that of a pea to a small marble, the fusiform deposit from a No. 12 catheter to a thumb in thickness, the length ranging between half and three-quarters of an inch.

Cause.—Repeated and neglected gonorrhœa seemed to be the *origo mali;* in some instances three or four attacks, in others five, six, and even seven had been incurred. In every case injection had been employed, and in not a few either self-treatment or treatment at the hands of unqualified persons and quacks.

Duration.—As a rule not less than eight or ten years, sometimes fifteen, twenty, and even thirty years.

Condition of Stricture on Admission, and Interval before Operation.—Spasm was the chief symptom in the triple stricture, and the fusiform always offered most resistance to the instrument. When the organic deposit was nodulated at three points, spasm was in most cases pretty equally divided amongst them, but not always. Dilatation as a rule was practised about six or seven days after admission.

Of the nineteen cases of bifold stricture four were

in an inflammatory state, and associated with albuminous urine, vesical catarrh, and lumbar pain; these were submitted to operation from twelve to fourteen days after admission. Congestion was the chief symptom in ten, and spasm in five cases; these were respectively operated upon from four to six days after treatment.

Age and Duration of Disease.—The youngest patient was 28, and had suffered 10 years, the oldest 60 and his stricture dated 40 years.

III. Stricture with Complications.

General Description.—We find complications attending every variety of the disease, whether traumatic or idiopathic, whether in the spongy or membranous portions of the urethra, and whether the stricture be in a state of spasm, congestion, or inflammation. The duration of the stricture in such cases varies from five to twenty-eight years. The respective complications may be enumerated as follows—viz., hæmaturia from bladder disease, false passages, albuminuria, cystitis, prostatic disease, fistula in perineo, ante and post scrotal fistulæ, perinæal urinary cyst, fæcal abscess, prolapsus ani, hæmorrhoids, hernia, hydrocele, sarcocele, incontinence of urine, suppuration of bladder, fistula in ano, valvular disease of the heart, chronic bronchitis and emphysema, cirrhosis of liver, paralysis agitans, and constitutional syphilis.

In all these cases the stricture and its complications were first palliated by a course of preliminary treatment, next the stricture was split, and at a subsequent period the concomitant diseases received further consideration. To illustrate this variety I may mention the case (Case VIII.) of a man aged 44, with a spasmodic fusiform stricture of the membranous portion of the urethra, associated with prostatic disease, and albuminuria. Sixteen years previously he was first attacked with retention of urine, and from that time, on and off, he had been attending the London hospitals for gradual dilatation, latterly, however, the small stream had become reduced to dribbling, and on admission his health was found fairly broken down, and the urine, which was loaded with albumen and pus, had a sp. gr. of 1015.

By rectum the prostate could be felt enlarged and somewhat obstructing the passage of the catheter; from the tenderness of that gland, and the grating sensation communicated to the hand by the instrument, I had a strong suspicion of a calculus being lodged there. After a course of ten days' preparatory treatment Holt's operation was performed, and the bladder was then washed out daily for a week (with acid: nitrici fort: ℥xx, liq: opii sed: ʒiv, aqua ad Oj), with decided benefit. He left the hospital, after nearly three weeks' residence, passing a good stream, free from albumen and other abnormal elements.

Notwithstanding the passage of a No. 12 catheter he now and then has irritation, referable to the prostate.

Of this variety there are twenty cases on my list, and I will briefly describe them without further classification, as each case presents some peculiarity.

Case I. is an example of an inflammatory traumatic fusiform stricture in the bulbo-membranous portion of the urethra of a patient aged 50, associated with hæmaturia from bladder disease (probably villous cancer) and chronic bronchitis and emphysema; the dimensions of the stricture were transversely half an inch, longitudinally three-fourths of an inch; its duration was twenty years. Dilatation was performed on the eighth day; a No. 11 catheter passed on the tenth, twelfth, and fourteenth days, and his further residence in the hospital, thirty-nine days, enabled me to treat the concomitant affections with marked success.—*See No.* 12 *in Appendix.*

Case II. is an instance of a spasmodic fusiform stricture of the membranous portion of the urethra, associated with prostatic disease (calculus?), false passages, albuminous urine, and cystitis. The patient was 44 years old, and had suffered sixteen years, after three severe attacks of gonorrhœa. Dilatation was accomplished on the tenth day, and he was discharged nine days subsequently, passing a good stream, and

greatly improved in every respect.—*See No.* 8 *in Appendix.*

Case III. exemplifies a congestive nodular traumatic stricture at the bulb in a patient aged 36, who had suffered nineteen years. This had been followed by abscesses, ante and post scrotal fistulæ, fæcal abscess, contraction of the bladder, and retention of urine. Puncture of the bladder per rectum was performed on admission, and fifteen days afterwards dilatation. (Case recorded in *Medical Times*, Feb. 11, 1871).—*See No.* 1 *in Appendix.*

Case IV. is an example of a spasmodic gristly stricture of the bulbo-membranous part in a man aged 48, which had existed twenty years, and had been followed by a large perinæal urinary cyst. Dilatation was performed on the fifth day, and he was discharged thirty-five days subsequently, passing a good stream, and with a complete cure of his cyst.—*See No.* 16 *in Appendix.*

Case V. illustrates a congestive fusiform bulbo-membranous stricture following a blow. The patient was 50 years of age, and had suffered twenty-eight years; constitutional syphilis, albuminous urine, catarrh of the bladder, and sarcocele were associated with the stricture. Dilatation was practised on the tenth day, and he was discharged three days later,

after the passage of a No. 12 catheter.—*See No.* 6 *in Appendix.*

Case VI. is an example of a spasmodic fibrous traumatic stricture like a finger, in front of the bulb; the patient, aged 36, had suffered fifteen years, and had latterly become affected with recto-vesical fistula and prolapsus ani. Dilatation on the fifth day; discharged on the thirty-fifth. Stricture admits a No. 12 bougie; other affections cured.—*See No.* 17 *in Appendix.*

Case VII. exemplifies an inflammatory fusiform bulbo-membranous stricture. The patient, aged 33, had suffered ten years, and during that time had incurred hernia, hydrocele, and hæmorrhoids, and subsequently a fracture of the tibia and fibula. Dilatation on the tenth day; discharged on the twenty-ninth; capacity of urethra normal; fractured limb placed in a starch bandage; bones united, but not firm enough to dispense with a support.—*See No.* 10 *in Appendix.*

Case VIII. is an instance of a spasmodic cartilaginous stricture one inch in extent midway between the meatus and the bulb, occurring in a patient aged 40, who had suffered ten years, and latterly become affected with albuminuria, catarrhus vesicæ, and ante-

scrotal fistula. Dilatation on the seventh day; urethra admitted a No. 12 on the thirteenth day. Discharged, after four months' residence, in the following condition: stricture well dilated; fistula cured by a plastic operation; bladder irritation absent; urine free from albumen.—*See No.* 5 *in Appendix.*

Case IX. illustrates a congestive nodular stricture (one inch in front of bulb) in a patient aged 27, of six years' duration, associated with suppuration of the bladder, incontinence of urine, and general emaciation. Dilatation on the fourteenth day; discharged on the forty-seventh day, in the following condition: urethral capacity normal; urine free from pus; incontinence absent; general health much improved.—*See No.* 15 *in Appendix.*

Case X. exemplifies a spasmodic, nodular, bulbous stricture of sixteen years' duration. The patient was 42 years of age, and affected with fistula in ano concomitantly. Dilatation on the fourth day; discharged on the fifty-ninth; urethral calibre normal; fistula cured.—*See No.* 11 *in Appendix.*

Case XI. illustrates a spasmodic, toughish, fibrous fusiform stricture of the spongy part of urethra an inch in front of the bulb, of twenty years' duration. The patient, aged 39, had latterly become troubled

with incontinence of urine and perinæal fistula. Dilatation ou the sixth day; discharged on the thirty-fourth in the following condition: stricture well dilated; incontinence subsided; perinæal fistula cured.—*See No.* 9 *in Appendix.*

Case XII. exemplifies an inflammatory cartilaginous traumatic stricture, occupying at least two inches of the spongy part of the urethra as far as the bulb in a patient aged 38. The disease dated fifteen years, and was associated with valvular disease of heart, albuminous urine, and cirrhosis of the liver. Dilatation on the ninth day; discharged on the fiftieth. Condition: stricture well dilated; urine free from albumen; general health improved.—*See No.* 13 *in Appendix.*

Cases XIII., XIV., XV., XVI., and XVII. resemble each other in regard to their association with hæmorrhoids, or prolapsus ani; the strictures varied in situation between the mid spongy part and one inch in front of the bulb; their character was more or less nodular, and their condition for the most part congestive; age varied between 25 and 43; duration from twelve to twenty years. Dilatation on the fourth day; discharged from fourteenth to forty-third days. Condition: stricture well dilated; concomitant affections cured.—*See Nos.* 2, 4, 14, 18, 19, *in Appendix.*

Cases XVIII., XIX., and XX. also resemble each other in respect of their association with chest complaints—viz., asthma, chronic bronchitis, and old pleurisy. In case xviii. (*Appendix*, No. 7) there was also chronic disease of the prostate gland, and in case xx. paralysis agitans. The strictures, for the most part, were confined to the spongy portion of the urethra, in one instance midway between the meatus and the bulb (*Appendix*, No. 20); in another, one and a-half inches from bulb (*Appendix*, No. 7), and in a third an inch off the meatus (*Appendix*, No. 3). Their character was chiefly fusiform, and their condition congestive. Age from 45 to 60; dilatation from the fifth to seventh day, discharged from ninth to thirty-fifth; and in all cases the stricture was well dilated.

A word now with respect to the instruments used prior to admission.

It must be understood that the foregoing cases were submitted to ordinary catheterism as out-patients, and may be divided according to the size of the instruments employed into four groups, viz.:—

(1.) Those which permitted a No. 1 catheter = nearly half the number.

(2.) Those which permitted a No. 2 catheter = $\frac{2}{3}$ths of the number.

(3.) Those which permitted a No. 3 catheter = $\frac{1}{3}$th of the number.

(4.) Those which permitted no instrument, however small, = rather more than $\frac{1}{8}$th of the number.

From various causes, local, constitutional, accidental, or social, gradual dilatation had accomplished little, hence the substitution of rapid dilatation after the admission of these cases into the hospital.

Preparatory Treatment for Holt's Operation.—I would here remark that my hospital patients have been for the most part in humble circumstances; with some, by incapacity for work, and hence slender resources, their bodily condition had become unfavourable to immediate operation, and in others the local disease was aggravated by habits of intemperance. With such contingencies I thought it necessary to pursue a very systematic course of treatment preliminary to operation, in order to improve the patient's general health, palliate the irritability of his urinary organs, and reduce the stricture to a passive state. Now organic stricture, in my experience, is liable to one of three active conditions—viz., spasm, congestion, or inflammation, either alone or combined. And although spasm is a more or less prominent feature of nearly every stricture, yet the true spasmodic organic stricture deserves especial attention. In severe cases we find it associated with complete spasms of the muscular fibres (described by Hancock and Kölliker) surrounding the urethra from the

meatus downwards, and the contraction becomes apparently intensified at the stricture. The urethra itself, in front, sometimes offers as much resistance to a small instrument as to a medium or full sized one, and when a catheter has been passed into the stricture this is occasionally so grasped that for some minutes its onward passage or withdrawal becomes difficult.

In these cases we sometimes find fistulæ behind the contraction in the scrotum, perinæum, or rectum, as the case may be.

Treatment comprises absolute rest in bed, hot baths every night for thirty or forty minutes, occasional purgatives, full doses of iron and opium, and a simple diet of slops. Generally after a period varying from four to twelve days, I have succeeded in readily dilating the stricture, and in many instances with the loss of not one drop of blood.

In the *congestive state of stricture* where there is probably more or less of submucous serous effusion in and around the deposit (particularly when that is extensive), it has been generally sufficient to confine the patient to bed for two or three days, to administer hot baths at night, to clear out the bowels with a dose of castor oil, and on the third or fourth day to dilate; in some cases, however, a longer period of preliminary treatment has been necessary.

In the *inflammatory state of stricture*, where there is pain of a bearing-down character and local tenderness, particularly on pressure, with more or less of ardor urinæ, and not unfrequently albuminous urine and catarrh of the bladder, good results follow leeching the coverings of the stricture, abstracting blood from the loins, dry cupping in the same region, administering full doses of bicarbonate and tartrate of potash in mucilage, confining the patient to bed and feeding him on slops with three or four ounces of gin daily; and so soon as all pain and tenderness have subsided, when the albumen in the urine becomes reduced and the specific gravity is not less than 1018, dilatation may be safely proceeded with.

Holt's Operation.—In performing this operation I have of late years followed the author's instructions, which I extract from his work on stricture (pages 8 and 9). Mr. Holt says, "The dilator having been previously well oiled, is to be introduced with the handle somewhat over the patient's left hip, and by keeping the convex portion gently pressing against the under part of the urethra, the point will glide along the upper portion until it is fairly beyond the triangular ligament, when, by bringing the handle to a right angle with the body and gradually depressing it—but not so much as in the passage of an ordinary

catheter—it will usually slip into the bladder.* The surgeon is next to place the point of the tube he has previously selected upon the wire between the blades, and thrust it as quickly as possible onwards to the end, by this means the stricture will be fairly split and not dilated—the former effect being necessary to obtain the best results. The dilator should now be rotated to separate still further the sides of the rent, and then be withdrawn, a catheter corresponding to the number of the tube being substituted for the purpose of removing the urine. The catheter is then to be taken out and the patient sent to bed."

After-Treatment,—Consists in keeping the patient

* My own practice is, before placing the tube upon the wire, to take the precaution to ascertain that the dilator is not grasped by the stricture, which is determined by slightly withdrawing the instrument and then gently rotating it. By this step, possibly, the urethra is less liable to contusion between the unyielding dilator and the tense stricture.

In my early operations I was accustomed to leave a catheter in the bladder during the first forty-eight hours, lest the urine flowing over the seat of dilatation, should irritate the mucous membrane, and give rise to infiltration and abscess; but on one occasion sloughing of the stricture tissue ensued, and although the patient ultimately recovered, ever afterwards I took the precaution to withdraw the catheter after evacuating the bladder.

I have always, with one exception, Case XXV. (1), introduced a large tube at once, and immediately after its withdrawal a No. 10 catheter. Very little pain seems to attend the operation, which is frequently bloodless, and in but one instance has it been necessary to administer chloroform.—J. D. H.

quiet in bed from twenty-four to forty-eight hours, to obviate local inflammatory action, in prescribing quinine and iron, and a non-stimulating diet, and on the third day in passing a No. 11 catheter—the latter is repeated on the fifth day, and when the general health permits he leaves the hospital to attend for occasional catheterism as an out-patient.

Results.—Of 120 operations I have had 118 recoveries and two deaths. Of the 118 cases, all with but one exception (a small urethra) admitted a No. 11 catheter on leaving the wards. The patients then attended for catheterism twice the first week, once the second and third, after that once a fortnight, and subsequently once a month. In some instances of simple stricture I have found it sufficient to pass an instrument once in two or three months, and where patients were unable to attend regularly, or obtain surgical aid elsewhere, I have instructed them to pass their own instruments.

Although false passages have given me some little trouble in the passage of the dilator, when the stricture had been fairly dilated and kept so, no further inconvenience has accrued. Four cases—(*see Appendix,*) Nos. 46, 61 (1); 9, 15 (2)—were allowed to relapse, and because the smaller instruments sometimes opened up the old false passages, I submitted them to re-dilatation with a good result.

Of the two deaths, one might have been accelerated by the operation, the other was independent of it, or rather a coincidence than a consequence; but I should also in justice state that ordinary treatment had failed in both cases; thus Holt's operation held out some hope as contrasted with the submission of the patient to the ordinary course of nature.

The first case (*Appendix*, No. 38) was that of a very weakly man, aged 42, who for many years had been troubled with an extensive cartilaginous stricture in the membranous part of the urethra, which from time to time had occasioned him much distress. Latterly, repeated attacks of retention of urine and irritability of the kidneys and bladder, had so seriously undermined his health, that he resolved to have some radical treatment attempted. Under these circumstances, he was submitted to a course of preliminary treatment, and then to ordinary catheterism. On no occasion, however, could an instrument larger than a No. 1 be introduced, and that always produced severe rigors. After a few days' rest, the dilator was therefore employed, and with facility; five days subsequently a sharp rigor was followed a few hours afterwards by an erythematous patch on the inner aspect of the right thigh, and next day tenderness and swelling in the course of the saphena major vein, which became obliterated twenty-four hours later. Rigors, followed

by sweating and diarrhœa, supervened; and on the eighth day plugging of the femoral vein gave rise to a dropsical condition of the whole limb. Shortly (six hours) afterwards, pus formed in the scrotum; and on the tenth day there was hypopyon of the right eye. The pulse now numbered 140 per minute, the urine became very albuminous, and 1012 in sp. gr.; and on the seventeenth day congestive pneumonia of both lungs terminated in death.

On a post-mortem examination, I observed the LUNGS were congested throughout, hepatized at their bases, and adherent to chest walls. The HEART was degenerated (muscular tissue microscopically fatty); the LIVER cirrhosed; the KIDNEYS were dilated, and structurally damaged; the URETERS dilated; the BLADDER was contracted, with hypertrophied walls; and there was suppuration beneath the urethra at the seat of stricture.

Now, sir, I wish particularly to invite your attention to the *second case.** This drawing, by Mr. Christopher D'Alton, our able artist, taken soon after death, faithfully depicts the post-mortem appearances of the urinary organs, and that portion of the penis which contains the stricture tissue.

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* The drawing (by Mr. C. D'Alton, artist to the Royal Free Hospital) exhibited.

The specimen* now before us is somewhat changed in colour by maceration in spirit; but it clearly shows that the submucous deposit is dilated to the normal calibre of the adjacent urethra; and we observe no breach of mucous membrane, no scar, no surrounding infiltration of serum, no purulent deposit, nor any appearance of disorganization of the sub-urethral textures; the mucous membrane is seen smooth and polished (covering the fusiform white glistening contractile tissue) without a trace of injury; in a word, the stricture was cured, although the patient died.

A few words about the case. (*See Appendix*, No. 50.)

The patient, a weakly man, aged 33, the subject of a fusiform stricture in the bulbo-membranous portion of the urethra, of an exceedingly spasmodic character, was, after a few days' preparatory treatment, under the influence of chloroform, submitted to Holt's operation; the urine was drawn off by a No. 11 catheter, and in the whole process not one drop of blood was lost.

On the third day afterwards, as there was no pain or tenderness, I passed a No. 12 catheter without any difficulty. He continued in his usual health until the following day, when he was about to leave the

* Specimen (from which the drawing was taken) exhibited.

hospital. Towards evening, however, he complained of feeling sick, and shortly afterwards vomited bile; vomiting continued four days, and at a later period was followed by rigors, fever, and delirium; subsequently the right parotid gland became inflamed and considerably swollen, and his countenance presented a very dusky hue. The urine continued to flow freely notwithstanding; and it was not until eight days later that its sp. gr. fell to 1014, and albumen appeared. Diarrhœa now set in; the pulse rose to 140 per minute; the skin became dry and harsh; and congestive pneumonia of both lungs was followed by death twenty-four hours afterwards.

Autopsy twenty-four hours post-mortem.

Head . . .	*Brain* substance healthy; *membranes* congested; *sinuses* turgid; *ventricles* distended.
Chest . . .	*Lungs* attached to chest by old adhesions, and congested; hepatized at bases.
	Heart fragile; muscular tissue degenerated and fatty; traces of old pericarditis; right cavities contained black blood; left empty; weight seven ounces.

Abdomen . { *Liver* cirrhosed; weight two pounds and a-half. *Kidneys* degenerated; pelvis dilated; ureters slightly enlarged; weight (right) four ounces; (left) four ounces and a-quarter. *Spleen* normal. *Bladder*, coats thickened; cavity lessened.

Parotid gland contained pus.

That this patient died of a blood poison I have no doubt; that fever, followed by parotiditis, uræmia, congestion of the meninges, and pneumonia, in a constitution weakened by organic disease, contributed mainly to that result is also certain, but we have no evidence to show that the operation was the direct or indirect cause of his death. Taking a fair view of the case, I am bound to consider the result as a coincidence rather than a consequence of the operation; and I am strengthened in the conclusion by the fact of there having been a fever case in the ward at the same time.

Conclusions respecting Holt's operation.

I maintain then that this operation is the most satisfactory method of treating any form of organic urethral stricture which is amenable to dilatation;

and that with careful attention to preliminary treatment, there is no more risk in its employment than in ordinary dilatation.

That where ordinary catheterism (gradual dilatation) is followed by severe symptoms, there Holt's operation is contraindicated.

That its advantages may be summarized as follows:—

1. Promptness in dilating the contracted part to the normal calibre of the urethra.

2. Immediate relief to the disturbed functions of the urinary organs.

3. Immediate benefit to the patient's health.

4. Freedom from chronic urethral discharge, so commonly excited by gradually increased and frequently repeated catheterism.

5. It is attended with scarcely more pain than ordinary catheterism, and rarely any hæmorrhage.

6. It is seldom followed by rigors, and freedom, as a rule, from subsequent inflammatory action.

7. It is better adapted to relapsing cases than any other form of treatment, the first operation not militating against a second or third.

8. That the rate of mortality is probably less than in gradual dilatation, when it is considered that a certain proportion of patients die from extravasation of urine, and from complications following ordinary catheterism.

IV. Cartilaginous Undilatable Stricture.

This variety of the disease is represented by twenty cases, which offer so many features in common that perhaps a general description of them will suffice. In every case either no instrument could be passed through the stricture, or when such was practicable serious symptoms ensued. Therefore a cutting operation was indicated and employed.

Situation.—For the most part the deposit extended from the spongy to the membranous portions of the urethra, implicating both structures, and it generally invaded from half an inch to one and a half inches of urethral territory.

Description.—Dense and firm to the touch, the stricture was generally felt beneath the skin of the perinæum and scrotum, implicating all textures as far as the urethra, and matting them together more or less; its transverse diameter measured sometimes one inch, at other times three-fourths, its longitudinal from half an inch to one and a half inches. In every instance the bladder was contracted and incapable of holding without pain, more than from five to ten ounces of urine, which in most instances was alkaline albuminous, of lower sp. gr. than usual (1014 to 1019) and containing mucus.

On introducing a small catheter this was often

firmly grasped by the stricture, but in some cases after a few minutes' pause, spasm abated, and the instrument passed through, conveying a creaking or grating sensation to the touch. In other cases repeated attempts with various sized catheters proved unsuccessful.

Rigors and fever more or less severe, invariably followed that proceeding, whether partial or complete, and in all cases the patients were cachectic.

Probable Cause.—Nine cases gave a history of external injury—either a blow to the perinæum or a fall astride; six were attributed to abscesses following gonorrhœa, and five to severe attacks of the latter, succeeded by long continued gleet.

Duration.—From fifteen to thirty years.

Condition of Stricture on Admission.—Spasmodic or more or less congestive.

Preparatory Treatment for Perinæal Section.—This comprises: (1) The confinement of the patient to a warm bed for a few days, in order to lessen that local congestion which is so often kept up by the erect posture and muscular movements, and to induce diaphoresis. (2) The administration of hot baths at bedtime, to improve cutaneous action—to lessen renal work, and to obviate stricture spasm. (3) The evacuation of the bowels, especially the rectum, with aperients and enemata, to prevent interruption or

retardation of the venous current about the perinæum, and the determination of blood to that locality. (4) The observance of a bland non-stimulating diet. With regard to medicines, I usually prescribe full doses of nitric acid with infusion of buchu or pareira, decoction of twitch or whortleberry, and ten minim doses of tinctura opii. And lastly, I treat co-existing complications upon ordinary principles.

Perinæal Section.—This operation consists of three varieties, viz:

(1.) Where the perinæum is opened and the stricture divided upon a staff which has been passed through it (Syme's operation).

(2.) Where a staff can be passed into the stricture but not through it, the latter being incised partly on the staff and partly behind it.

(3.) Where no staff can be inserted into the stricture—i.e., section—without a guide.

In all cases I have administered chloroform, for the double purpose of producing anæsthesia and facilitating the passage of a staff, and the patient has been always placed in the usual position for lithotomy.

In five cases no instrument could be passed into the stricture; in three a small Syme's staff entered the stricture but failed to pass through; in six a No. $\frac{1}{2}$, and in the same number of cases a No. 1 staff were

respectively inserted until the shoulder of each instrument rested against the fore part of the stricture.

In the three cases of partial insertion, the staff having been held by an assistant, a free incision in the mesian line of the perinæum, about two inches long externally, was carried through all structures until the groove of the staff was reached. The posterior part of the stricture tissue, and that part which locked the instrument, having been next divided, the staff was then passed on until its shoulder rested against the anterior part, which was now liberated by reversing the edge of the knife and cutting upwards. The urethra being free the staff was withdrawn, and a No. 10 silver catheter introduced and secured with tapes.

In those cases where a No. $\frac{1}{2}$ or a No. 1 was inserted, the shoulder of the staff was first cut down upon, and the stricture then divided from before backwards. But where no guide could be passed I introduced a No. 7 silver catheter as far as the contraction; the patient was then placed in the lithotomy position and the tip of the instrument made to impinge on the forefinger of the left hand, which was placed in the perinæum; this was attained by turning the catheter with its concavity towards the operator (who was facing the perinæum), the finger then being firmly pressed against the point of the instrument while its handle was returned to its original position, i.e., in

the mesian line flatwise upon the abdomen; the instrument was finally transferred to an assistant and held, with the penis made tense upon it, so that its point rested against the anterior part of the stricture. A free incision in the raphé was now carried boldly down to the point of the catheter, and continued through the whole stricture into the urethra behind. The latter in all cases was found dilated, and recognised by its inverted pen-nib-like fissure (made by the cut) and smooth upper surface. Lastly, the staff was withdrawn and a male catheter passed per meatum into the bladder, and retained there. In three cases this was accomplished, but in two, where thickening was excessive, a female catheter, guided by a director, was inserted through *the wound.*

Now when should we remove the perinæal catheter? In a case where urinary infiltration through tortuous perinæal fistulæ had kept up subacute inflammation and great thickening, I found it desirable to retain the female catheter in the perinæum four days; and in another case, where the same condition was aggravated by acute gonorrhœa and balanitis, I found it necessary to keep the instrument in fourteen days before having recourse to catheterism. Also in a case of traumatic stricture, where thickening was so extensive that no metallic instrument with a curve could be passed beyond the

membranous part of the urethra, even after the abatement of local congestion and urinary infiltration, there also the perinæal catheter was retained fourteen days, when a flexible one was entered per meatum urethræ.

To summarize the points in the operation, then, we have to note—

1. The production of anæsthesia.
2. The lithotomy position.
3.
   a. The passage of a Syme's staff through the stricture; that failing—
   b. The passage of a staff into the stricture; that failing—
   c. The passage of a staff as far as the stricture.
4.
   a. The free perinæal incision upon and into the groove of the staff, and the section of the stricture from before backwards.

   Or,

   b. The free incision into the staff through the median portion of the stricture, the section of the posterior part beyond the staff, its passage onwards; and finally, the liberation of its shoulder by division of the anterior portion of the stricture.

   Or,

   c. The bold mesian incision carried through the stricture from the point of a catheter in front to the sound urethra behind.

5. The pen-nib-like fissure made by opening the sound urethra posterior to stricture—the guide for the catheter to the bladder.
6. The retention of a full-sized catheter along the whole course of the urethra. That failing, a female catheter through the wound.

The After-Treatment comprises attention to the *general health*, and to the local disease. With regard to the former, during the first forty-eight hours I have prescribed a milk diet; after that a dose of castor-oil to relieve the bowels, and then tonic medicines and a generous diet, with a liberal allowance of stimulants and opiates at night, when such have been necessary. As to the latter, after forty-eight hours I have generally removed the catheter and substituted a flexible one a size larger. Where primary hæmorrhage has been troublesome—a rare occurrence—I have removed the instrument, plugged the wound around a short perinæal catheter, and tied the legs together. On the third day the sponges have been detached by the injection of olive oil through the wound, and the female catheter has been withdrawn, cleansed, and re-introduced, or a No. 11 flexible male catheter inserted per meatum urethræ.

Results.—Of the twenty patients submitted to perinæal section every one recovered, and may be said to be cured, so far as stricture cases are curable. Usually

the wound healed in five or six weeks over the instrument, but perinæal fistulæ have sometimes given me trouble. In such cases I have taught my patients to draw off their own urine three times a day with a full-sized catheter, which has generally been followed by a good result. Occasionally, however, it has been necessary to vivify the edges by section or cauterization.

In all cases I employ or recommend catheterism on a sliding scale, at intervals varying from once a fortnight to once a quarter afterwards.

Conclusions respecting Perinæal Section.—I hold that this operation is a satisfactory mode of treating impermeable stricture of the bulbous and membranous portions of the urethra, and those cases of permeable stricture of the same regions, where the passage of any instrument, however small, is followed by severe symptoms. That its advantages consist in—

(1.) Promptness in attaining the normal calibre of the urethra, and immediate relief to the urinary organs by the passage and retention of a full-sized catheter, either through the meatus or perinæum.

(2.) That neither rigors nor any serious constitutional disturbance follow its employment, and that the loss of blood is usually inconsiderable.

(3.) That there is seldom any inflammatory action in the wound, which generally granulates over a flexible catheter in five or six weeks, and that the patient is not necessarily confined to bed the whole of that time.

(4.) That the patient's health undergoes immediate improvement.

(5.) That catheterism is necessary on a sliding scale, at intervals of two, four, six, eight, ten, or twelve weeks afterwards.

(6.) That in case of a relapse a second operation is to be preferred to any other kind of treatment, and that the first operation does not militate against a second.

To conclude. I crave the indulgence of the Fellows for the imperfections of this paper; and in thanking them for a kind and patient hearing, I would simply state that I have brought before the Society a collection of facts in favour of two of the most important surgical operations for the prompt and satisfactory treatment of urethral stricture—operations which, in my humble judgment, by prolonging life and lessening human suffering, have conferred incalculable benefits upon mankind, and shed lustre on the names of their distinguished authors.

(1.) SINGLE STRICTURE.—HOLT'S OPERATION—(*continued*).

No.	*Name.*	*Age.*	*Nature of Stricture and Situation.*	*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks.*
33	William T.	57	Spasmodic semilunar, bulbo-membranous part.	Sept. 11, 1869.	11th day.	Nov 10, 1869.	Scrotal fistulæ—healed.
34	Charles H. A.	26	,, ,, ,,	Sept. 23, 1869.	8th ,,	Oct. 6, 1869.	
35	Thomas F.	58	,, annular ,,	Dec. 8, 1869.	4th ,,	Dec. 15, 1869.	
36	George N.	28	,, ,, ,,	Nov. 4, 1867.	4th ,,	Nov. 14, 1867.	
37	Henry W.	22	,, ,, ,,	Oct. 12, 1870.	5th ,,	Oct. 23, 1870.	
38	Walter D.	42	,, cartilaginous, membranous part.	Feb. 10, 1868.	9th ,,	March 7, 1868.	Death.
39	Charles O.	30	,, ,, ,,	July 6, 1867.	8th ,,	Aug. 6, 1867.	
40	Henry F.	55	,, ,, ,,	Jan. 19, 1870.	12th ,,	March 1, 1870.	Perinæal fistula—healed. Spasmodic condition of urethra.
41	Henry S.	28	,, semilunar, bulbo-membranous.	Jan. 22, 1870.	4th ,,	Jan. 29, 1870.	
42	Edward D.	44	,, ,, ,,	Feb. 2, 1870.	5th ,,	Feb. 17, 1870.	Albuminuria.
43	Thomas H.	38	,, ,, ,,	April 14, 1870.	10th ,,	May 14, 1870.	Recto-vesical fistula—healed.
44	George W.	26	,, bridle, bulbo-membranous part.	May 21, 1870.	4th ,,	May 27, 1870.	
45	Thomas F.	48	,, ,, ,,	May 30, 1870.	4th ,,	June 14, 1870.	
46	Charles G.	29	,, ,, ,,	May 28, 1870.	4th ,,	June 8, 1870.	False passages. 2nd dilatation.
47	William S.	50	,, ,, ,,	June 2, 1870.	5th ,,	June 14, 1870.	

48	James P.	37	Spasmodic bridle, bulbo-membranous part.			June 7, 1870.	4th day.	June 13, 1870.	
49	Henry P.	28	,,	,,	,,	June 22, 1870.	4th ,,	June 30, 1870.	
50	J. Edward S.	33	,,	fusiform	,,	Aug. 10, 1870.	3rd ,,	Aug. 28, 1870.	Death.
51	James G.	38	,,	annular	,,	Dec. 19, 1868.	4th ,,	Dec. 29, 1868.	
52	Edward T.	48	,,	,,	,,	July 24, 1868.	4th ,,	Aug. 12, 1868.	
53	William A.	23	,,	bridle	,,	Sept. 2, 1868.	4th ,,	Sept. 16, 1868.	
54	Henry S.	40	,,	,,	,,	July 13, 1867.	4th ,,	July 30, 1867.	
55	Charles H.	30	,,	,,	,,	May 25, 1867.	6th ,,	June 6, 1867.	
56	James C.	42	,,	,,	,,	May 26, 1869.	12th ,,	June 26, 1869.	Recto-vesical fistula —healed.
57	John C.	25	,,	,,	,,	Aug. 18, 1867.	10th ,,	Sept. 7, 1867.	Scrotal fistulæ — healed.
58	Thomas M.	22	,,	,,	,,	Aug. 31, 1867.	4th ,,	Sept. 7, 1867.	
59	Henry W.	28	,,	,,	,,	Oct. 12, 1867.	4th ,,	Oct. 23, 1867.	
60	Richard B.	26	,,	,,	,,	Oct. 26, 1867.	4th ,,	Nov. 1, 1867.	
61	George N.	30	,,	,,	,,	Nov. 4, 1867.	4th ,,	Nov. 14, 1867.	False passages. 2nd dilatation.
62	George S.	29	,,	,,	,,	Dec. 27, 1867.	4th ,,	Jan. 4, 1867.	
63	Charles W.	40	,,	,,	,,	May 14, 1868.	4th ,,	May 28, 1868.	
64	Henry G.	38	,,	,,	,,	May 30, 1868.	4th ,,	June 8, 1868.	
65	George M.	27	,,	,,	,,	Oct. 8, 1868.	4th ,,	Oct. 14, 1868.	
66	Edward D.	31	,,	,,	,,	Oct. 24, 1868.	4th ,,	Oct. 31, 1868.	
67	Thomas S.	27	,,	,,	,,	July 8, 1869.	4th ,,	July 14, 1869.	
68	Alfred S.	51	,,	,,	,,	Dec. 23, 1869.	4th ,,	Dec. 31, 1869.	
69	John O'C.	23	,,	,,	,,	Dec. 29, 1869.	4th ,,	Jan. 3, 1870.	

(2.) MULTIPLE STRICTURE.—HOLT'S OPERATION.

No.	*Name.*	*Age.*	*Nature of Stricture.*	*Situation.*			*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks.*
				TRIPLE.						
				1st.	2nd.	3rd.				
1	Thomas M.	39	Spasmodic triple nodular stricture.	2 in. from meatus.	Midway between 1st and bulb.	Bulbo-membranous junction.	Mar. 20, 1867.	6th day.	April 12, 1867.	In all these cases the stricture was well dilated.
2	James C. .	28	Ditto nodulo-fusiform.	1¾ ditto.	Ditto.	Ditto.	Feb. 24, 1867.	7th „	Mar. 10, 1867.	
3	John T. .	29	„ „ „	2¼ ditto.	Ditto.	Ditto.	Jan. 20, 1867.	7th „	Mar. 3, 1867.	
4	John P. .	60	„ „ „	2 ditto.	Ditto.	Chiefly bulbous.	Dec. 21, 1869.	6th „	Dec. 31, 1869.	
5	George F. .	32	„ „ „	Ditto.	Ditto.	Ditto.	Nov. 17, 1869.	6th „	Nov. 27, 1869.	
6	Francis H .	31	„ „ „	Ditto.	Ditto.	Ditto.	Aug. 16, 1870.	7th „	Sept. 12, 1870.	
7	Benjamin B.	39	„ „ „	Ditto.	Ditto.	Chiefly membranous.	Dec. 3. 1869.	6th „	Dec. 23, 1869.	
8	Frederick A.	53	„ „ „	Ditto.	Ditto.	Chiefly bulbous.	Aug. 13, 1869.	6th „	Aug. 31, 1869.	
9	Thomas G.	41	„ „ „	Ditto.	Ditto.	Ditto.	Sept. 3, 1868.	7th „	Oct. 5, 1868.	False passages; 2nd dilatation by Holt's inst.
10	George W. .	32	„ „ „	1¾ ditto.	Ditto.	Bulbo-membranous.	Nov. 1, 1867.	7th „	Dec. 13, 1867.	
11	Elijah B.	26	„ „ „	2 ditto.	Ditto.	Ditto.	Oct. 22, 1867.	6th „	Nov. 20, 1867.	
12	Richard Y.	39	„ nodular stricture.	Ditto.	Ditto.	Ditto.	Aug. 30, 1867.	7th „	Sept. 13, 1867.	Varicocele.

				Bifold.					
				1st.	2nd.				
13	Henry B. .	28	Inflammatory bifold nodulo-fusiform.	About midway between meatus and bulb.	At bulbo-membranous junction.	Aug. 23, 1867.	12th day.	Sept. 7, 1867.	Varicocele.
14	John D. .	29	Ditto nodular.	Ditto.	Ditto.	Oct. 4, 1867.	13th ,,	Oct. 19, 1867.	
15	Walter B. .	28	,, ,,	Ditto.	Chiefly membranous portion.	Nov. 5, 1867.	14th ,,	Nov. 28, 1867.	False passages; 2nd dilatation by Holt's process.
16	John E. .	25	,, ,,	Ditto.	Ditto.	Sept. 1, 1867.	12th ,,	Sept. 17, 1867.	
17	Thomas A.	45	Congestive ditto.	Ditto.	Bulbo-membranous portion.	Oct. 18, 1867.	4th ,,	Nov. 1, 1867.	
18	Francis B.	25	,, ,,	Ditto.	Ditto.	July 13, 1869.	4th ,,	July 23, 1869.	
19	John C. .	46	,, ,,	Ditto.	Ditto.	Sept. 29, 1870.	5th ,,	Oct. 12, 1870.	
20	Edward G.	25	,, ,,	Ditto.	Ditto.	Sept. 27, 1870.	6th ,,	Oct. 14, 1870.	
21	Richard N.	28	,, ,,	Ditto.	Ditto.	Oct. 2, 1866.	5th ,,	Oct 10, 1866.	
22	Philip R. .	40	,, ,,	Ditto.	Ditto.	Aug. 19, 1866.	4th ,,	Aug. 26, 1866.	
23	George G. .	30	,, ,,	Ditto.	Ditto.	April 29, 1866.	4th ,,	May 10, 1866.	
24	Charles P.	27	,, ,,	Ditto.	Ditto.	Jan. 13, 1866.	6th ,,	Feb. 23, 1866.	
25	Wm. H. N.	28	Ditto bifold nodulo-fusiform.	Ditto.	Ditto.	Sept. 2, 1869.	5th ,,	Sept. 25, 1869.	
26	Henry B. .	29	Ditto ,, nodular.	Ditto.	Ditto.	Aug. 8, 1868.	4th ,,	Aug. 13, 1868.	
27	Frederick W.	44	Spasmodic ditto.	Ditto.	Ditto.	June 3, 1868.	4th ,,	June 22, 1868.	
28	Thomas G.	34	,, ,,	Ditto.	Ditto.	Nov. 4, 1868.	5th ,,	Dec. 7, 1868.	
29	William K.	36	,, ,,	Ditto.	Ditto.	Aug. 6, 1866.	6th ,,	Aug. 30, 1866.	
30	George H. .	48	,, ,,	Ditto.	Ditto.	Dec. 22, 1866.	4th ,,	Jan. 5, 1867.	
31	John L. .	42	,, ,,	Ditto.	Ditto.	Dec. 21, 1867.	4th ,,	Jan. 26, 1868.	

(3.) STRICTURE WITH COMPLICATIONS.—HOLT'S OPERATION.

No.	*Name.*	*Age.*	*Nature of Stricture, and Situation.*	*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks. Complications.*
1	Thomas D.	36	Congestive nodular traumatic stricture of bulb.	July 14, 1869.	15th day.	Dec. 8, 1869.	Ante and post-scrotal fistulæ; fæcal abscess; retention of urine; puncture of bladder per rectum. Holt's operation; see *Medical Times*, Feb. 11, 1871.
2	Joseph S.	38	Congestive nodular idiopathic, between mid-spongy and bulbous parts.	Feb. 20, 1867.	4th ,,	April 3, 1867.	Hæmorrhoids—cured; stricture well dilated.
3	William G.	45	Congestive fusiform, near meatus.	Sept. 7, 1868.	7th ,,	Oct. 12, 1868.	Chronic bronchitis, emphysema; stricture well dilated.
4	Walter McD.	30	Congestive nodular, 1 inch from bulb.	Dec. 10, 1866.	4th ,,	Dec. 24, 1866.	Hæmorrhoids—cured; stricture well dilated.
5	Elijah B.	40	Spasmodic cartilaginous mid-bulbo-meatal.	Aug. 18, 1870.	7th ,,	Dec. 22, 1870.	Ante-scrotal fistula; vesical catarrh and albuminous urine. Stricture well dilated; fistula cured; urine free from albumen.

6	Walter P.	50	Congestive fusiform bulbo-membranous.	March 3, 1868.	10th day.	March 16, 1868.	Constitutional syphilis; sarcocele; vesical catarrh; albuminous urine. Stricture well dilated; urine free from albumen; general health improved.
7	John B.	60	Congestive fusiform, $1\frac{1}{2}$ inches from bulb.	March 8, 1868.	5th ,,	March 19, 1868.	Old pleurisy; asthma; chronic bronchitis and enlargement of prostate. Stricture well dilated.
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10	Benjamin B.	33	Inflammatory fusiform bulbo-membranous.	July 1, 1868.	10th ,,	July 29, 1868.	Hernia; hydrocele; hæmorrhoids; fracture of tibia and fibula. Stricture well dilated; bones united, but not quite firm enough to leave off supports; other affections to be treated subsequently.
11	Charles B.	42	Spasmodic nodular bulbous.	July 10, 1870.	4th ,,	Sept. 7, 1870.	Fistula in ano. Urethral calibre normal; fistula cured.

(3.) STRICTURE WITH COMPLICATIONS.—HOLT'S OPERATION.

No.	*Name.*	*Age.*	*Nature of Stricture, and Situation.*	*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks. Complications.*
1	Thomas D.	36	Congestive nodular traumatic stricture of bulb.	July 14, 1869.	15th day.	Dec. 8, 1869.	Ante and post-scrotal fistulæ; fæcal abscess; retention of urine; puncture of bladder per rectum. Holt's operation; see *Medical Times*, Feb. 11, 1871.
2	Joseph S.	38	Congestive nodular idiopathic, between mid-spongy and bulbous parts.	Feb. 20, 1867.	4th ,,	April 3, 1867.	Hæmorrhoids—cured; stricture well dilated.
3	William G.	45	Congestive fusiform, near meatus.	Sept. 7, 1868.	7th ,,	Oct. 12, 1868.	Chronic bronchitis, emphysema; stricture well dilated.
4	Walter McD.	30	Congestive nodular, 1 inch from bulb.	Dec. 10, 1866.	4th ,,	Dec. 24, 1866.	Hæmorrhoids—cured; stricture well dilated.
5	Elijah B.	40	Spasmodic cartilaginous mid-bulbo-meatal.	Aug. 18, 1870.	7th ,,	Dec. 22, 1870.	Ante-scrotal fistula; vesical catarrh and albuminous urine. Stricture well dilated; fistula cured; urine free from albumen.

6	Walter P.	50	Congestive fusiform bulbo-membranous.	March 3, 1868.	10th day.	March 16, 1868.	Constitutional syphilis; sarcocele; vesical catarrh; albuminous urine. Stricture well dilated; urine free from albumen; general health improved.
7	John B.	60	Congestive fusiform, $1\frac{1}{2}$ inches from bulb.	March 8, 1868.	5th ,,	March 19, 1868.	Old pleurisy; asthma; chronic bronchitis and enlargement of prostate. Stricture well dilated.
8	William E. M.	44	Spasmodic fusiform membranous.	Aug. 17, 1869.	10th ,,	Sept. 5, 1869.	Cystitis; false passages; albuminous urine; prostatic disease. Stricture well dilated; generally improved.
9	William C.	39	Spasmodic fibrous fusiform, 1 inch from bulb.	Feb. 15, 1869.	6th ,,	March 20, 1869.	Incontinence of urine — relieved; perinæal fistula — cured; stricture well dilated.
10	Benjamin B.	33	Inflammatory fusiform bulbo-membranous.	July 1, 1868.	10th ,,	July 29, 1868.	Hernia; hydrocele; hæmorrhoids; fracture of tibia and fibula. Stricture well dilated; bones united, but not quite firm enough to leave off supports; other affections to be treated subsequently.
11	Charles B.	42	Spasmodic nodular bulbous.	July 10, 1870.	4th ,,	Sept. 7, 1870.	Fistula in ano. Urethral calibre normal; fistula cured.

(3.) STRICTURE WITH COMPLICATIONS—HOLT'S OPERATION—(*continued*).

No.	*Name.*	*Age.*	*Nature of Stricture, and Situation.*	*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks. Complications.*
12	Charles B.	50	Inflammatory traumatic fusiform bulbo-membranous.	Sept. 13, 1867.	8th day.	Nov. 5, 1867.	Hæmaturia from vesical disease; chronic bronchitis and emphysema. Stricture well dilated; associated affections relieved.
13	Edward S.	38	Inflammatory cartilaginous spongio-bulbous.	July 18, 1870.	9th ,,	Sept. 6, 1870.	Valvular disease of heart; albuminuria; cirrhosis. Stricture well dilated; urine free from albumen; general health improved.
14	Elijah H.	43	Congestive nodular mid-spongy.	March 13, 1869.	4th ,,	April 17, 1869.	Hæmorrhoids and prolapsus ani. Stricture well dilated; other affections cured.
15	Adam W.	27	Congestive nodular, 1 inch from bulb.	Nov. 4, 1868.	14th ,,	Dec. 21, 1868.	Suppuration of bladder; dribbling; general prostration. Stricture well dilated; urine free from pus; general health improved.
16	James S.	48	Spasmodic gristly bulbo-membranous.	Sept. 1, 1868.	5th ,,	Oct. 10, 1868.	Perinæal cyst connected with urethra. Stricture well dilated; cyst cured.

17	John M.	36	Spasmodic fibrous traumatic, just in front of bulb.	Sept. 21, 1868.	5th day.	Oct. 26, 1868.	Recto-vesical fistula and prolapsus ani. Stricture well dilated; concomitant affections cured.
18	William W.	35	Congestive nodular, 1½ inches from bulb.	Feb. 23, 1868.	4th ,,	April 2, 1868.	Hæmorrhoids and prolapsus ani—cured. Stricture well dilated.
19	John A.	25	Congestive nodular, 2 inches from bulb.	Sept. 14, 1868.	4th ,,	Oct. 19, 1868.	Hæmorrhoids—cured. Stricture well dilated.
20	John C.	60	Congestive fusiform, mid-spongy.	Feb. 23, 1869.	5th ,,	March 3, 1869.	Old bronchitis; emphysema and contraction of chest from old pleurisy; paralysis agitans. Stricture well dilated.

(4.) CARTILAGINOUS UNDILATABLE STRICTURE.—PERINÆAL SECTION.

No.	*Name.*	*Age.*	*Situation of Stricture.*	*Date of Admission.*	*Date of Operation.*	*Date of Discharge.*	*Remarks.*
1	Edward L.	56	Spongio - membranous part, 1½ inches in extent.	Oct. 1, 1869.	Oct. 9	Nov. 5, 1869.	No. ½ Syme's staff passed; wound granulated; same operation by Mr. Erichsen ten years ago.
2	Thomas B.	48	,, ,, ,,	June 24, 1869.	July 3	Aug. 11, 1869.	No guide; wound granulated; Syme's operation by the author (Syme) 8 years previously.
3	Edward S.	40	,, 1 inch ,,	April 17, 1869.	April 20	May 24, 1869.	No. 1 staff passed; wound healed by granulation.
4	Robert A.	43	,, 1½ inches ,,	Jan. 12, 1869.	Jan. 19	March 31, 1869.	,, ,, ,,
5	James T.	45	,, 1¼ ,, ,,	Dec. 17, 1868.	Jan. 4	Feb. 23, 1868.	No. ½ ,, ,,
6	Joseph S.	43	,, 1 inch ,,	Nov. 18, 1868.	Nov. 20	Dec. 23, 1868.	No guide ,, ,,
7	James A.	46	——	Feb. 19, 1868.	Feb. 22	April 1, 1868.	,, ,, ,,
8	Thomas D.	35	,, 1¼ inches ,,	July 14, 1869.	July 17	Dec. 8, 1869.	,, wound granulated, leaving a small fistula, which healed after vivification.

9	Denis C.	55	,, 1½ inches ,,	Dec. 23, 1867.	Dec. 24	Jan. 28, 1867.	,, wound healed by granulation.
10	Joseph S.	45	,, 1 inch ,,	July 10, 1867.	July 12	Aug. 21, 1867.	No. ½ ,, ,,
11	John E.	55	,, 1½ inches ,,	July 22, 1867.	July 24	Aug. 29, 1867.	,, failed to pass through the stricture, ditto.
12	Thomas P.	46	,, 1 inch ,,	Jan. 16, 1867.	Jan. 26	March 3, 1867.	,, ,, ,,
13	Henry S.	40	——	Dec. 27, 1866.	Dec. 29	Feb. 2, 1867.	,, ,, ,,
14	Arthur H.	30	,, 1½ inches ,,	Sept. 23, 1866.	Sept. 27	Oct. 20, 1866.	,, passed ,, ,,
15	D. McG.	45	,, 1 inch ,,	June 15, 1866.	June 18	July 27, 1866.	,, ,, ,,
16	James W.	43	——	May 6, 1866.	May 10	June 14, 1866.	,, ,, ,,
17	Benjamin S.	44	,, 1 ,, ,,	Dec. 14, 1866.	Dec. 17	Jan. 27, 1867.	No. 1 ,, ,,
18	John V.	37	——	June 29, 1866.	July 2	Aug. 31, 1866.	,, ,, ,,
19	Samuel R.	55	,, 1½ inches ,,	Oct. 4, 1870.	Oct. 8	Dec. 13, 1870.	,, wound healed by granulation, except at its extremities, where fistulæ formed, but these closed up after cauterization.
20	John C.	39	,, 1 inch ,,	Sept. 5, 1870.	Sept. 6	Dec. 4, 1870.	,, passed, wound granulated.
							N.B.—All these cases admitted a No. 11 or 12 catheter on leaving the hospital

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